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City of Huntington v. AmerisouceBergen Drug Corp. et al, 17cv01362

Witness Name: Robert Knittle (WVa Board of Medicine)

Deposition Date: 8/27/2020

White = Defendants' Affirmative Designations (w/ Plaintiffs' Objections and Defendants' Replies)

Blue = Plaintiffs' Completeness Designations (w/ Defendants' Objections and Plaintiffs' Replies)

Pink = Defendants' Reply Designations (w/ Plaintiffs' Objections and Defendants' Replies)

Designations	Objections	Reponses
8:22 - 9:03 8:22 Q. Good morning, Mr. Knittle. I introduced 8:23 myself a little bit earlier. My name is Sandy 8:24 Zerrusen, and as I stated earlier, I represent 9:01 AmerisourceBergen Drug Corporation. Could you 9:02 please state your full name for the record? 9:03 A. Yes, my full name is Robert Clare Knittle.		
25:20 - 26:06 25:20 Q. And where did you go after Pressley Ridge? 25:21 A. After that -- I was there for about 12 or 25:22 13 years, and then I moved on to the Board of 25:23 Medicine in the State of West Virginia as the 25:24 executive director there. 26:01 Q. And when did you start that position? 26:02 A. It was December of 2005. 26:03 Q. And I believe you said earlier you retired 26:04 January 1st of 2017? 26:05 A. Yes. My last day of work was December 26:06 31st, 2016.		
26:13 - 27:09 26:13 Q. Perfect. During your time at the Board, 26:14 were you involved in any professional associations? 26:15 A. Yes. 26:16 Q. Okay. Which ones? 26:17 A. The Federation of State Medical Boards. 26:18 Q. Okay. Is that FSMB? 26:19 A. Yes, it is. 26:20 Q. Okay. And what was your involvement with 26:21 FSMB? 26:22 A. Represented the State of West Virginia at 26:23 the -- at a national level. I was involved in 26:24 several other aspects of the Federation Board. 27:01 Q. Can you describe to me what the Federation 27:02 of State Medical Boards is? 27:03 A. Yes. It's a organization that helps assist 27:04 state boards of medicine for the United States. 27:05 Q. And how do they help assist them? 27:06 A. They help supply organization information 27:07 that can be shared across states. They assist in 27:08 the licensing of physicians. It's 27:09 more administrative in nature.		
27:10 - 27:24 27:10 Q. Did you find during your tenure at the 27:11 Board that FSMB was helpful for you in your 27:12 position? 27:13 A. Yes, I would -- I would say so. I think it 27:14 was a two-way street. I was -- I was involved in a 27:15 number of their projects as well. 27:16 Q. Okay. Do you remember what projects you 27:17 were involved with them in? 27:18 A. I sat on the medical directors -- state 27:19 medical directors advisory panel to the Federation 27:20 of State Medical Boards. 27:21 And I also sat on their advisory 27:22 council to the United States Medical License 27:23 Examination, USMLE, when they went through their 27:24 changes of their steps.	**Re: [27:10 to 27:24]** Relevance.	**Re: [27:10 to 27:24]** Relevant to the deponent's background. Defendants designated this additional questioning in response to Plaintiffs' objection that designations on page 29 required additional foundation.

Designations	Objections	Reponses
28:16 - 29:05 28:16 Q. Did any of the changes in the content that 28:17 you were involved in relate to controlled 28:18 substances or prescribing? 28:19 A. Not specifically. There may have been 28:20 questions in there that dealt with opioids or the 28:21 prescribing of them. But they were nothing that 28:22 was specifically focused on as part of the 28:23 examination. 28:24 Q. Okay. You also said that you were on an 29:01 advisory panel. What was that? 29:02 A. It was a -- basically when issues would 29:03 come up that -- at a national level, they would ask 29:04 from -- for input from different medical directors 29:05 across the country.	**Re: [28:16 to 29:5]** Relevance; Hearsay	**Re: [28:16 to 29:5]** Relevant to the deponent's background. Defendants designated this additional questioning in response to Plaintiffs' objection that designations on page 29 required additional foundation. The questions do not call for hearsay.
29:06 - 29:19 29:06 Q. Did -- were any of the issues that you 29:07 dealt with, did any of them relate to controlled 29:08 substances or prescribing? 29:09 A. I think there was some discussion. And I 29:10 can't be real specific about it because I can't 29:11 remember. But -- but there was talk about, you 29:12 know, some type of a template for states to look at 29:13 in terms of developing policy for training and 29:14 education regarding opiates for physicians. 29:15 Q. Regarding prescribing? Excuse me. 29:16 A. Well, the whole process of -- like you were 29:17 talking about, you know, someone coming in asking 29:18 for pain management of some nature. Some were more 29:19 specific than others as to exactly what they want.	**Re: [29:06 to 29:19]** Vague; Lack of Foundation; Lack of Personal Knowledge; Hearsay	**Re: [29:06 to 29:19]** The question is not vague, and this form objection is waived for not having been made at the deposition. However, in response to plaintiffs' objection, defendants added reply designations at pages 27 and 28 to provide additional context. The question specifically asks about "issues that [the deponent] dealt with," so it does not lack foundation or personal knowledge. The question also does not elicit hearsay, because the deponent's statement that "there were some discussions" is not offered for truth of any statement, but for his understanding of FSMB's focus and activities.
29:20 - 29:24 29:20 Q. And did you participate in coming up with 29:21 this template? 29:22 A. No, I did not. 29:23 Q. Okay. All right. Were you involved with 29:24 any other professional associations while at the		
30:01 - 30:24 30:01 Board? 30:02 A. There was a group called the Administrators 30:03 In Medicine. 30:04 Q. Okay. 30:05 A. And that is a -- the medical directors -- 30:06 or the directors of the medical boards across the 30:07 country, and it was just kind of a subgroup that 30:08 was distinct, at least, from a -- from a nonprofit 30:09 standpoint. 30:10 Q. For the Administrators in Medicine, was 30:11 there anything involving controlled substances, 30:12 education or training? 30:13 A. I think there was always discussion about 30:14 it. There was nothing that was independently 30:15 developed by that group. 30:16 Q. And what would be discussed about it? 30:17 A. The number -- or I guess the outright 30:18 concern of the number of deaths that were being 30:19 caused by opioids and what the role would be of 30:20 legitimate drugs in the deaths of those people.		

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30:21 Q. Okay. And what was discussed about the 30:22 role of the legitimate drugs? 30:23 A. Well, generally, the boards of medicine 30:24 deal with physicians and the licensing and		
31:01 - 31:04 31:01 disciplining of physicians, so we were looking at 31:02 things in terms of education for physicians, 31:03 awareness of the -- of the dangers of using 31:04 opioids.		
31:10 - 31:15 31:10 Q. Any other professional associations during 31:11 your time at the Board? 31:12 A. I don't believe so. I sat on the initial 31:13 board for the -- for the general licensing of 31:14 physicians across the state -- or across the 31:15 country.	**Re: [31:10 to 31:15]** Relevance	**Re: [31:10 to 31:15]** This question is relevant to establish Mr. Knittle's background and experience.
32:09 - 32:18 32:09 Q. Okay. A little bit ago, you were talking 32:10 about when you were at the Board, you were 32:11 concerned with the licensing and discipline of 32:12 physicians. Was that kind of the main purpose of 32:13 the Board of Medicine? 32:14 A. Yeah, the main purpose is to protect the 32:15 public. And the way that the Board is structured 32:16 legally is for the licensing and disciplining of 32:17 physicians, which would include physician 32:18 assistants as well.		
33:16 - 33:24 33:16 Q. Okay. Can you give me just a rundown of 33:17 what your duties were as executive director at the 33:18 Board? 33:19 A. Basically to carry out the wishes of the -- 33:20 of the Board of Medicine, to oversee the staff 33:21 during that implementation, and to maintain a 33:22 physical presence as well as to be available to the 33:23 legislative body and other groups on behalf of the 33:24 Board of Medicine.		
37:24 - 38:08 37:24 Q. And how many licensees did the Board 38:01 oversee generally when you were there? 38:02 A. I'm trying to think. Around 3000. 38:03 Q. And that would include all three 38:04 specialties? 38:05 A. I think there were about 800 P.A.'s and 38:06 there were several hundred - but it was declining - 38:07 of podiatrists. I think there was around 3000 or 38:08 3200 physicians.	**Re: [37:24 to 38:08]** Relevance; Vague	**Re: [37:24 to 38:08]** This question is not vague, and this form objection is waived for not having been made during the deposition. The question is relevant as background on both Mr. Knittle's experience and the role of the WV Board of Medicine, which regulates all doctors in West Virginia, including in Cabell County and Huntington.
39:07 - 40:09 39:07 Q. We were talking about the DEA registration 39:08 or license. Do you understand why a doctor would 39:09 need a DEA registration or license before 39:10 prescribing a controlled substance? 39:11 A. I believe it's to try to appropriately 39:12 monitor them across the country. 39:13 Q. And a prescription for an opioid that's 39:14 written by a Board licensee must be for a 39:15 legitimate medical purpose. Correct? 39:16 A. Yes. 39:17 Q. And you agree with me that prescription 39:18 opioids can serve a legitimate medical purpose,	**Re: [39:07 to 40:09]** Lack of Foundation; Calls for Expert Opinion; Lack of Personal Knowledge; Speculation; Scope	**Re: [39:07 to 40:09]** The question does not call for expert opinion or lack foundation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role. The scope objection is

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39:19 correct? 39:20 A. They can, yes. 39:21 Q. That patients can benefit from the use of 39:22 opioids being prescribed for a legitimate medical 39:23 purpose, correct? 39:24 A. Yes. 40:01 Q. Okay. And you agree that it could -- can 40:02 be appropriate for pharmacists to fill a 40:03 prescription for opioids for a patient, correct? 40:04 A. I believe that's their role, yes. 40:05 Q. Yes. And it's the physician that makes the 40:06 ultimate decision whether or not to prescribe an 40:07 opioid for a legitimate medical purpose to their 40:08 patient, correct? 40:09 A. That's correct.		unfounded as this was a fact deposition, and in any case this question focuses on his work at the Board of Medicine.
40:10 - 40:24 40:10 Q. And does a prescriber need to consider a 40:11 patient's history prior to prescribing an opioid? 40:12 A. I believe they do. 40:13 Q. How about their diagnosis? 40:14 A. Yes. That would be, in part, determined by 40:15 the physician. 40:16 Q. Okay. Anything else that a prescriber 40:17 needs to consider when prescribing an opioid that 40:18 you know of? 40:19 A. No. Again, not being a physician, I can't 40:20 get real specific as to exactly how diagnoses and 40:21 prescribing are specifically determined by a 40:22 physician to a patient. 40:23 Q. Okay. Should anybody be second-guessing 40:24 the physician's decision to prescribe an opioid?		
41:01 - 41:24 41:01 A. Some people will go for a second opinion. 41:02 Q. Okay. Other than a patient going for a 41:03 second opinion, is there anybody that should be 41:04 questioning a physician's decision to prescribe an 41:05 opioid to his or her patient? 41:06 A. I think if someone has concerns over it 41:07 that, you know, that's why the Board of Medicine is 41:08 there, for one aspect. But there are a number of 41:09 different controls throughout the system for 41:10 different aspects of the system. 41:11 We don't live in a perfect world, and 41:12 you know, some people will take advantage of things 41:13 for financial gain or -- in some respects for 41:14 physicians, for sexual gain. 41:15 But mostly, it's -- from what we've 41:16 seen, it's been monetary. 41:17 Q. And what do you mean that they will take 41:18 advantage for financial gain? What will they do? 41:19 A. They will overprescribe. 41:20 They will ask for kickbacks, knowing 41:21 that a patient would, you know, sell them, and they 41:22 wanted a portion of it. 41:23 Or to get part of the pills back 41:24 themselves.		
42:01 - 42:24 42:01 Q. When you say they ask for kickbacks, are 42:02 they asking for kickbacks from the patient 42:03 themselves? 42:04 A. Yes. 42:05 Q. Okay. Can you explain that a little more 42:06 to me. 42:07 A. No, I think there have been instances where 42:08 someone would, you know, cash -- or fill the 42:09 prescription, sell the medications and give a 42:10 portion of the money back to the physician. 42:11 Q. Okay. And you -- during your tenure at the		

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42:12 Board, you have seen instances where physicians 42:13 were writing prescriptions for controlled 42:14 substances for sexual favors? 42:15 A. Yes. 42:16 Q. Okay. You said that there are certain 42:17 controls in the system. Besides the Board of 42:18 Medicine, what other controls are there in the 42:19 system? 42:20 A. Well, things like the DEA -- 42:21 Q. Okay. 42:22 A. -- who monitor how they're distributed and 42:23 who's distributing them. I think from the Board of 42:24 Pharmacy side and from the national side, I know		
43:01 - 43:24 43:01 that there are particular controls as to monitoring 43:02 of all sorts of the different types of controlled 43:03 substances or drugs or prescribed drugs. 43:04 But they monitor where they're going, 43:05 how much is going, those sorts of things. 43:06 Q. You said the DEA monitors how they are 43:07 distributed and who distributes them. Do you know 43:08 who distributes them? 43:09 A. No. 43:10 Q. Okay. Do you know how they are 43:11 distributed? 43:12 A. Not specifically. We -- our focus was, you 43:13 know, those sorts of things had always been beyond 43:14 the purview of the Board of Medicine, and even if 43:15 we were curious about something, there's -- there 43:16 were times that we just didn't have access to that 43:17 type of information. 43:18 Q. Were there times that you tried to gain 43:19 access to that type of information? 43:20 A. Not specifically, no. Unless it was very 43:21 specifically related to a particular case of a 43:22 physician or P.A. -- 43:23 Q. Okay. 43:24 A. -- or podiatrist.		
44:01 - 44:08 44:01 Q. Did the Board of Medicine while you were 44:02 there work with the DEA? 44:03 A. Yes, on individual cases. 44:04 Q. As you sit here today, can you identify an 44:05 instance where a person overdosed on a controlled 44:06 substance that they were taking as it was 44:07 prescribed to them by their physician? 44:08 A. No. Not after -- not after years, I can't.	**Re: [44:01 to 44:08]** Lack of Foundation; Calls for Expert Opinion; Lack of Personal Knowledge; Speculation; Scope	**Re: [44:01 to 44:08]** The question does not call for expert opinion or lack foundation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role. The scope objection is unfounded as this was a fact deposition, and in any case this question focuses on his work at the Board of Medicine.
44:09 - 44:21 44:09 Q. Is it something that you think has 44:10 happened? 44:11 A. As prescribed? 44:12 Q. Yes. 44:13 A. It's very possible that it did. 44:14 Q. You just, as you sit here today, can't 44:15 think of an instance? 44:16 A. No, it's -- but you know, there have been 44:17 instances of inappropriate prescribing where 44:18 perhaps they prescribed a higher dose than was 44:19 necessary.		

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44:20 Those would be particularly rare. But 44:21 I imagine that anything is possible.		
44:22 - 45:07 44:22 Q. Okay. Do you know of an instance where a 44:23 drug distributor asked a physician to write a 44:24 prescription for a controlled substance? 45:01 A. Not specifically, no. 45:02 Q. Okay. When you say, "not specifically," do 45:03 you think there is an instance and you just can't 45:04 remember it, or -- 45:05 A. No, I don't think there was anything within 45:06 the Board of Medicine that I can remember a 45:07 specific complaint of that nature.	**Re: [44:22 to 45:07]** Relevance; Lack of Foundation; Lack of Personal Knowledge; Scope	**Re: [44:22 to 45:07]** The question does not lack foundation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role. The scope objection is unfounded as this was a fact deposition, and in any case the question focuses on his work with the Board of Medicine.
52:20 - 53:08 52:20 Q. So in most or all of the overprescribing 52:21 cases, the Board would get an expert to determine 52:22 whether or not the physician had been 52:23 overprescribing? 52:24 A. Yes. I think after probable cause is 53:01 found, some physicians will settle the case, will 53:02 go on for, you know, medical education or something 53:03 like that. 53:04 Others will -- are more adamant about 53:05 their own innocence in the matter, and those will 53:06 -- are the ones that we will get, you know, a -- an 53:07 expert for testimony at a hearing, administrative 53:08 hearing.	**Re: [52:20 to 53:08]** Compound; Relevance; Vague; Lack of Foundation	**Re: [52:20 to 53:08]** The question is not compound or vague. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role, as the testimony relates directly to the analysis that the Board believed was necessary to assess the legitimacy of prescribing. Plaintiffs have affirmatively offered testimony about both prescribing patterns and Board of Medicine disciplinary action through their expert Lacey Keller, rendering any relevance objection unfounded.
53:23 - 54:11 53:23 Q. And you talked about the administrative 53:24 hearing. Who oversees an administrative hearing? 54:01 A. An administrative judge. 54:02 Q. Okay. And does that administrative judge 54:03 then make a recommendation to the Board? Or do 54:04 they make a ruling? 54:05 A. Yeah, they make a -- they make a ruling 54:06 that would be taken to the Board for a 54:07 determination, and the Board can either accept it, 54:08 reject it or modify it. 54:09 Q. Okay. So the Board makes the ultimate 54:10 decision on discipline. 54:11 A. They do.	**Re: [53:23 to 54:11]** Relevance	**Re: [53:23 to 54:11]** The existence of and processes involved in the disciplining of prescribers in West Virginia is relevant, and Plaintiffs have affirmatively placed these facts at issue through their expert witness, Lacey Keller.

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57:01 - 57:24 57:01 11:14 a.m. We are on the record. 57:02 BY MS. ZERRUSEN: 57:03 Q. Mr. Knittle, earlier we were talking about 57:04 overprescribing. And I take it from your testimony 57:05 that there were licensees of the Board that 57:06 overprescribed; is that correct? 57:07 A. Yeah, there have been physicians that have 57:08 been disciplined for inappropriate prescribing. 57:09 Q. And when is the first time that you can 57:10 recall a licensee was disciplined for inappropriate 57:11 or overprescribing? 57:12 A. I don't know the specific instance. I 57:13 mean, they have been disciplining physicians for 57:14 that for decades prior to me being there. 57:15 Q. Okay. And was every licensee that the 57:16 Board investigated and found had overprescribed, 57:17 was every one of them disciplined? 57:18 A. To some degree. If there's, you know, an 57:19 abundance of evidence. 57:20 Q. And earlier we talked about diversion. Is 57:21 overprescribing diversion? 57:22 A. Not necessarily. 57:23 Q. Okay. 57:24 A. It could -- it could lend itself to		
58:01 - 58:21 58:01 diversion, but -- 58:02 Q. So the overprescribing itself is not 58:03 diversion, it's what the patient then does with 58:04 those pills that they were overprescribed? 58:05 A. That would be determined by the intent of 58:06 the physician. 58:07 Q. Okay. 58:08 A. If they're in collaboration, it could be 58:09 diversion, yes. 58:10 Q. And did -- during your tenure at the Board, 58:11 did that happen where physicians were in 58:12 collaboration with their patient to overprescribe? 58:13 A. I think there have been some instances of 58:14 it, but I can't be specific. 58:15 Q. Okay. Would those physicians have been 58:16 disciplined? 58:17 A. Yes. 58:18 Q. Would you agree with me that diversion is 58:19 illegal? 58:20 A. Yes. I believe so. Either from an 58:21 administrative or criminal standpoint or both.		
59:17 - 59:24 59:17 Q. Okay. Were there any other things that 59:18 licensees of the Board did related to opioids that 59:19 they were disciplined for? 59:20 A. Perhaps their use of them themselves 59:21 personally. 59:22 Q. And would those licensees have been 59:23 disciplined? 59:24 A. They could be disciplined, but they --		
60:01 - 60:24 60:01 generally, they were in a point of probably 60:02 addiction themselves and it would be specific as to 60:03 whether they were impaired at the time that they 60:04 were practicing as well as whether they were using 60:05 inappropriately. 60:06 Q. Did the Board work with licensees that were 60:07 addicted themselves to get them treatment? 60:08 A. Yes, we did. In fact, I think one of the 60:09 first things that we were able to pass when I came 60:10 on as the executive director was establishment of a 60:11 physicians health program in West Virginia. 60:12 Q. And what's the physicians health program?		

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60:13 A. It's the program that works with physicians 60:14 that have alcohol or drug abuse or addiction 60:15 issues, and to some degree, mental illness. 60:16 Q. And why do physicians need a specific 60:17 program for themselves? 60:18 A. I think just because of the seriousness of 60:19 the situation with them that physicians - or 60:20 anybody that's involved with drugs - can do a 60:21 tremendous amount of damage if they're not on top 60:22 of their -- of their game. 60:23 Q. Okay. And did the Board work with the 60:24 physicians health program?		
61:01 - 61:08 61:01 A. Yes. 61:02 Q. Okay. And how did they collaborate? How 61:03 did the two agencies collaborate? 61:04 A. There's a -- there's an agreement between 61:05 the Board of Medicine and the physicians health 61:06 program as well as specific legislature in 61:07 establishing it, that put together the guidelines 61:08 as to how we worked.		
61:09 - 61:12 61:09 Q. And what was the agreement between -- 61:10 between the two? 61:11 A. It was a -- it was a matter of mutually 61:12 sharing information under proper circumstances.	**Re: [61:9 to 61:12]** Relevance; Hearsay	**Re: [61:9 to 61:12]** This is a completeness designation given Plaintiffs' designation of the immediately preceding and immediately following testimony on the same subject, making clear its relevance. The Board of Medicine's standards for disciplining prescribers is relevant. The question does not call for hearsay.
62:04 - 62:08 62:04 Q. Okay. Was the physicians health program 62:05 successful in treating addiction? 62:06 A. Yes. And in fact, the model that we 62:07 established in West Virginia has been emulated 62:08 across the country by a number of different states.		
62:09 - 62:10 62:09 Q. So addiction can be treated. 62:10 A. Yes, it can.	**Re: [62:09 to 62:10]** Vague; Lack of Foundation; Calls for Expert Opinion	**Re: [62:09 to 62:10]** The question does not call for expert opinion or lack foundation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role, as he is discussing specific programs that the Board of Medicine participated in to assist with treatment of addiction among licensed prescribers.

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63:04 - 63:08 63:04 Q. Okay. During your tenure at the Board, 63:05 were licensees required to take continuing 63:06 education related to pain management? 63:07 A. They were required to do continuing 63:08 education, yes.	**Re: [63:04 to 63:08]** Vague; Relevance	**Re: [63:04 to 63:08]** The question is not vague. The knowledge and training of physicians in West Virginia is relevant and at issue in this case, including through Plaintiffs' affirmative introduction of prescribing records and Board of Medicine discipline with expert witness Lacey Keller.
65:17 - 66:09 65:17 Q. Do you recall this requirement for the 65:18 licensees to take two hours of continuing education 65:19 on end-of-life care, including pain management? 65:20 A. Yes, I do. And the emphasis there was -- 65:21 was on the end-of-life care. 65:22 Q. Okay. And why was the emphasis on 65:23 end-of-life care? 65:24 A. Just in order for people to be able to not 66:01 go through any unnecessary pain in terminal illness 66:02 cases. 66:03 Q. Was this always a requirement, a continuing 66:04 education requirement, while you were at the Board? 66:05 A. Yeah, I believe it was there before I 66:06 started. 66:07 Q. Okay. Was it there when you -- through 66:08 when you left? 66:09 A. To my recollection, yes.	**Re: [65:17 to 66:09]** Relevance	**Re: [65:17 to 66:09]** Please see prior response regarding Plaintiffs' relevance objection.
70:09 - 70:24 70:09 Q. Earlier when we were talking about the 70:10 disciplinary process, I believe you said that there 70:11 were two investigators employed by the Board? 70:12 A. Yeah, for years we only had one. 70:13 Q. Okay. 70:14 A. But with the amount of -- of complaints and 70:15 the complexity of the inappropriate prescribing 70:16 cases that were coming up, then it was necessary to 70:17 hire a second investigator. 70:18 Q. And do you recall what year that was? 70:19 A. You know, I wish I did, but I don't. 70:20 Q. Why were inappropriate prescribing cases 70:21 complex? 70:22 A. Because I think you eventually have to 70:23 establish that the prescribing itself was 70:24 inappropriate, so you needed to get all the		
71:01 - 71:11 71:01 records, all of the prescription records, and put 71:02 them together in a meaningful way in order to try 71:03 to make a determination of that. 71:04 So it's a very tedious process in 71:05 order to do it. 71:06 Q. Okay. I'm assuming - which is probably not 71:07 good to do during a deposition - that based on your 71:08 testimony, the amount of inappropriate prescribing 71:09 cases increased during your -- over your tenure at 71:10 the Board. Is that correct? 71:11 A. It did.		
74:20 - 74:24 74:20 Q. Do you recall if -- if the opioid-related 74:21 cases were concentrated in a particular geographic 74:22 area of West Virginia? 74:23 A. They were more southern than they were 74:24 northern. Huntington, Wayne County, Mingo, down		

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75:01 - 75:07 75:01 towards the Beckley area. We had a number of cases 75:02 through there, as well as around the Charleston 75:03 area. 75:04 That is not to say that there were not 75:05 cases in the Eastern Panhandle or Morgantown area, 75:06 but there were quite a few in the southern part of 75:07 the state.		
75:08 - 75:12 75:08 Q. Do you have any idea why? 75:09 A. No. I don't. There's a lot of different 75:10 theories that the people cast about as to issues of 75:11 addiction in Appalachia. But I don't have a 75:12 specific one.	**Re: [75:8 to 75:12]** Improper Opinion; Hearsay; Lack of Foundation; Lack of Personal Knowledge	**Re: [75:8 to 75:12]** The question asks for the deponent's own personal understanding, so does not lack foundation or personal knowledge. The document does not call for hearsay or for any "improper opinion." It asks the deponent if he has knowledge of the reasons behind a trend in cases that he stated he has personal knowledge of.
76:19 - 77:01 76:19 Q. Did the investigators have the ability to 76:20 look at the West Virginia Controlled Substances 76:21 Monitoring Program? 76:22 A. I believe that they did. 76:23 Q. Okay. And if I call it "the CSMP," will 76:24 you understand that it's the West Virginia 77:01 Controlled Substances Monitoring Program?	**Re: [76:19 to 77:01]** Lack of Foundation; Lack of Personal Knowledge; Speculation; Vague (including time-frame); Relevance	**Re: [76:19 to 77:01]** The question is not vague and does not lack foundation of call for speculation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role, as they relate specifically to the work of investigators at the agency he ran.
77:02 - 77:13 77:02 A. Yeah. I don't think that was always in 77:03 existence. 77:04 Q. Okay. 77:05 A. And it came on to -- towards the latter 77:06 part of my tenure with the Board. 77:07 Q. Do you know why the CSMP was implemented? 77:08 A. I think to try to get a better handle on 77:09 what was being distributed and supplied and 77:10 distributed to physicians and patients then. 77:11 Q. Do you know what the -- what information 77:12 the CSMP contains? 77:13 A. I can't specifically recall.		
77:14 - 77:24 77:14 Q. Okay. Do you know who maintains the CSMP? 77:15 A. It had been the Board of Pharmacy, if it's 77:16 still there. 77:17 Q. Okay. Prior to the CSMP, what would the 77:18 investigators look at to try to get information 77:19 regarding dosages and prescribing of physicians? 77:20 A. It would be a subpoena of medical records 77:21 of a physician or particular patients. 77:22 Q. Was the CSMP a helpful tool then once it 77:23 came about? 77:24 A. I believe it was helpful.	**Re: [77:14 to 77:24]** Lack of Foundation; Lack of Personal Knowledge; Speculation; Vague (including time-frame); Relevance	**Re: [77:14 to 77:24]** Please see prior response.

Designations	Objections	Reponses
78:19 - 78:22 78:19 Q. Do you know if prescribers of controlled 78:20 substances were required to register with the CSMP? 78:21 A. I think they were. I thought that was a 78:22 change in -- in law from the Board of Pharmacy.	**Re: [78:19 to 78:22]** Lack of Foundation; Lack of Personal Knowledge; Speculation; Vague (including time-frame); Relevance	**Re: [78:19 to 78:22]** Please see prior response.
79:01 - 79:24 79:01 Q. All right. Can you pull out Tab 14? 79:02 COURT REPORTER: Sandy, will this be 79:03 Exhibit 3? 79:04 KNITTLE DEPOSITION EXHIBIT NO. 3 79:05 (WVBOM Quarterly Newsletter, Volume 79:06 14, Issue 1, January-March 2010 was 79:07 marked for identification purposes as 79:08 Knittle Deposition Exhibit No. 3.) 79:09 A. You guys like our newsletters, huh? 79:10 Q. I tried to get other stuff. This is all I 79:11 got. All right. So this is going to be marked as 79:12 Exhibit 3 to your deposition. It is the West 79:13 Virginia Board of Medicine Quarterly Newsletter, 79:14 Volume 14, Issue 1, January through March 2010. 79:15 And if you look near the bottom of the 79:16 page, it discusses the committee substitute for 79:17 Senate Bill 365 and Senate Bill 514. You want to 79:18 take a minute and read those two paragraphs? 79:19 A. Okay. 79:20 Q. All right. So for Senate Bill 365, it says 79:21 that by at least July 1st, 2011, prescribers of 79:22 controlled substances must have access to the CSMP. 79:23 Correct? 79:24 A. Yes.	**Re: [79:01 to 79:24]** Improper narrative; Hearsay; Relevance	**Re: [79:01 to 79:24]** These questions lay foundation for the exhibit introduced at page 79. No form objection was made during the deposition and is waived.
80:17 - 80:21 80:17 Q. So if a physician had -- was checking the 80:18 CSMP, they'd be able to see if their patient had 80:19 been going from doctor to doctor to doctor to try 80:20 to get different controlled substances, right? 80:21 A. Correct.	**Re: [80:17 to 80:21]** Calls for Expert Opinion; Speculation; Lack of Foundation; Vague (including time-frame)	**Re: [80:17 to 80:21]** The question is not vague and does not lack foundation or call for speculation or expert opinion. No form objection was made during the deposition and is waived. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role, as they relate specifically to the State's regulation of prescribers and information sources made available to prescribers.
81:04 - 81:11 81:04 Q. Okay. It also says that Senate Bill 365 81:05 "limits liability of practitioners for good faith 81:06 reliance on the" CSMP database. Do you know what 81:07 the purpose of limiting the liability of the 81:08 practitioners was? 81:09 A. Well, the first response is it would be to 81:10 curb malpractice cases against them if they were 81:11 prescribing opioids.	**Re: [81:04 to 81:11]** Hearsay; Lack of Foundation; Calls for a Legal Conclusion; Calls for Expert Opinion; Vague	**Re: [81:04 to 81:11]** Please see prior response.

Designations	Objections	Reponses
82:15 - 82:24 82:15 Q. Okay. If you go -- the Senate Bill 514, it 82:16 says, "controlled substance reporting when a 82:17 prescription is filled for a controlled substance 82:18 or a controlled substance is dispensed." 82:19 A. Yes. 82:20 Q. The only information that is then reported 82:21 to the CSMP would be when a controlled substance is 82:22 filled or dispensed by a pharmacy or a doctor that 82:23 dispenses it out of their office? Is that right? 82:24 A. Yes.	**Re: [82:15 to 82:24]** Hearsay; Lack of Foundation; Calls for a Legal Conclusion; Calls for Expert Opinion; Vague	**Re: [82:15 to 82:24]** Please see prior response.
85:16 - 85:19 85:16 Q. And in fact, it would be helpful for 85:17 physicians to check the CSMP prior to writing a 85:18 prescription for an opioid, right? 85:19 A. Yes.	**Re: [85:16 to 85:19]** Speculation; Lack of Foundation; Calls for Expert Opinion; Vague (including time-frame)	**Re: [85:16 to 85:19]** Please see prior response.
85:20 - 86:02 85:20 Q. And what should the prescriber be looking 85:21 for when they check the CSMP? 85:22 A. Well, apparently -- if it was a physician, 85:23 then you would be looking at a particular patient 85:24 to see if they had been to five different 86:01 physicians over a certain period of time looking 86:02 for a particular type of drug or treatment.	**Re: [85:20 to 86:02]** Speculation; Lack of Foundation; Calls for Expert Opinion; Vague (including time-frame)	**Re: [85:20 to 86:02]** Please see prior response.
88:01 - 88:06 88:01 Q. Okay. If a doctor was being investigated 88:02 for inappropriate or overprescribing, would their 88:03 license or their ability to prescribe be put on 88:04 hold in any sort of way during the investigative 88:05 process? 88:06 A. Generally not.	**Re: [88:01 to 88:06]** Vague; Relevance	**Re: [88:01 to 88:06]** The question is not vague. The disciplinary processes employed by the Board of Medicine are relevant to this case, including through Plaintiffs' affirmative introduction of prescribing records and Board of Medicine discipline with expert witness Lacey Keller.
88:07 - 88:21 88:07 Q. Okay. 88:08 A. If it was a case where it was -- it was 88:09 extremely severe, that you had an overdose of -- 88:10 deaths of five people because of prescribing, 88:11 sometimes there's a legal means in order to, you 88:12 know, suspend someone on an emergency basis and 88:13 have a quick hearing. 88:14 That was extremely rare -- 88:15 Q. Okay. 88:16 A. -- for that -- for that to happen. 88:17 Q. Do you recall -- 88:18 A. So -- 88:19 Q. Sorry. 88:20 A. -- until probable cause is found, people 88:21 are able to practice.		
88:22 - 89:01 88:22 Q. Do you recall an instance where there were 88:23 deaths of several people that somebody's ability to 88:24 prescribe was almost immediately revoked? 89:01 A. No.	**Re: [88:22 to 89:01]** Relevance	**Re: [88:22 to 89:01]** This is a completeness designation given Plaintiffs' designation of the immediately preceding testimony on the same subject, making clear its relevance. The Board of Medicine's standards for disciplining prescribers is relevant.

Designations	Objections	Reponses
89:02 - 89:06 89:02 Q. Okay. But it is an option for the Board to 89:03 immediately revoke somebody's ability to prescribe 89:04 or practice medicine. 89:05 A. There is that -- there is that aspect in an 89:06 immediate situation.	**Re: [89:02 to 89:06]** Vague; Relevance	**Re: [89:02 to 89:06]** The question is not vague. The disciplinary processes employed by the Board of Medicine are relevant to this case, including through Plaintiffs' affirmative introduction of prescribing records and Board of Medicine discipline with expert witness Lacey Keller.
89:12 - 89:22 89:12 Q. What types of discipline could be doled out 89:13 to a physician? Starting with the harshest penalty 89:14 to the lightest penalty. 89:15 A. Well, you could permanently lose your 89:16 license, would probably be the harshest. You know, 89:17 probably the least severe would be some type of 89:18 continuing medical education. 89:19 Sometimes community service. But that 89:20 was rarely used. 89:21 Q. Could somebody's license be suspended? 89:22 A. Yes, that's in the middle.	**Re: [89:12 to 89:22]** Vague; Relevance	**Re: [89:12 to 89:22]** Please see prior response.
93:15 - 94:03 93:15 Q. Do you know what the "epidemic of 93:16 prescription drug fraud" is? 93:17 A. I think that's what we were talking about, 93:18 where people would alter prescriptions or steal 93:19 prescription pads. 93:20 Q. Okay. Do you know how long this epidemic 93:21 lasted? 93:22 A. No. But given how quickly the legislative 93:23 acts, it was probably a number of years. 93:24 Q. Are you saying that they -- they don't act 94:01 that quickly? 94:02 A. No, they -- they usually take their time on 94:03 these things.	**Re: [93:15 to 94:03]** Speculation; Hearsay; Lack of Foundation; Vague; Relevance	**Re: [93:15 to 94:03]** The question is not vague nor does it lack foundation or call for speculation. The question relates to Deposition Exhibit 3, which is a Board of Medicine publication, and the deponent was the Executive Director of the Board of Medicine for twelve years. The question references the newsletter to ask if the deponent understands terms used therein, not for the truth of any statements in the newsletter, and therefore is not calling for hearsay. Issues related to prescription drug fraud are relevant to this case, which deals with the alleged misuse and abuse of prescription opioids.
94:04 - 94:07 94:04 Q. Okay. 94:05 A. Until it comes to their attention to a 94:06 strong enough point where it becomes legislatively 94:07 necessary.		
101:24 - 101:24 101:24 Q. Was there a time when the standard of care		
102:01 - 102:24 102:01 was to treat with opioids? 102:02 A. I think it was professed by some people to 102:03 do that, that narcotics was the thing that you 102:04 should start out with first and foremost. 102:05 And there were some physicians that 102:06 prescribed to that approach. But it was not 102:07 generally very effective and as the addictions rose 102:08 and the deaths rose, it was really called into 102:09 question.		

Designations	Objections	Reponses
102:10 Q. You said it was professed by people. Do 102:11 you know who professed it? 102:12 A. I think some of the pharmaceutical 102:13 manufacturers had pushed for it pretty heavily. 102:14 Q. Do you know what the Joint Commission on 102:15 the Accreditation of Hospitals is? 102:16 A. I'm aware of what -- that that entity 102:17 exists, yes. 102:18 Q. Okay. Do you know what they do? 102:19 A. They accredit hospitals as to appropriate 102:20 means of patient care, safety, medical treatment. 102:21 Q. Do you remember guidance from the Joint 102:22 Commission that pain should be treated as the fifth 102:23 vital sign? 102:24 A. I don't know if they adopted that or --		
103:01 - 103:24 103:01 actually, I think it was a pharmacy that started 103:02 that, and people were led to believe that that was 103:03 truly a medical basis when in fact it wasn't. 103:04 It was more of a marketing scheme. 103:05 Q. Did pain being seen as the fifth vital sign 103:06 change the way that physicians prescribed pain 103:07 medication? 103:08 A. I don't think it ever came up a great deal 103:09 in our complaint process as to whether they fell 103:10 back to that as a line of defense. 103:11 Q. What did come up in the complaint process 103:12 as a line of defense for inappropriate prescribing? 103:13 A. On which case? There's -- 103:14 Q. Was there an excuse or something that 103:15 people used regularly? 103:16 A. You know, some people were -- and there was 103:17 a very select few physicians who adamantly believed 103:18 that narcotics was the first and only treatment. 103:19 But that standard of care caused a 103:20 tremendous amount of addiction and deaths when you 103:21 look back on those particular cases. 103:22 You know, others -- there was a whole 103:23 range of -- of rationale as to why they did what 103:24 they did.		
104:01 - 104:24 104:01 Q. You just said, "that standard of care 104:02 caused a tremendous amount of addiction and 104:03 deaths." 104:04 A. Yes. 104:05 Q. What about standard of care caused 104:06 addiction and deaths? 104:07 A. If someone actually believed that the only 104:08 way to deal with any kind of pain was high dosages 104:09 of opioids, then the end result for people is that 104:10 they would become addicted, you know, a vast 104:11 majority of the time, and would abuse the drug, 104:12 seek other ways to get it or get their dosages 104:13 increased by that physician. 104:14 And a number of times, if they mixed 104:15 it with alcohol or whatever, they died. 104:16 Q. And that was a problem with some of the 104:17 Board's licensees, that they -- that was their view 104:18 of the standard of care? 104:19 A. Yes. 104:20 Q. Okay. How -- how would the Board know 104:21 about physicians that believed this kind of 104:22 standard of care? 104:23 A. Their own testimony. 104:24 Q. Okay. Other than receiving a complaint,		
105:01 - 105:04 105:01 would the Board be able to investigate a doctor 105:02 regarding the standard of care?		

Designations	Objections	Reponses
105:03 A. No. The Board doesn't have the capacity to 105:04 initiate their own complaints.		
106:02 - 106:14 106:02 Q. So Mr. Knittle, could you define for me, 106:03 when we've just been talking about standard of 106:04 care, what is your definition of "standard of 106:05 care?" 106:06 A. I think it's an approach by a particular 106:07 physician as to what he feels is the best way to 106:08 manage a medical issue. 106:09 Q. Okay. And when you say the standard of 106:10 care caused addictions and deaths, what do you mean 106:11 by "standard of care" in that statement? 106:12 A. That some physicians had believed that the 106:13 best way to treat pain was for high and consistent 106:14 amounts of opioids.	**Re: [106:02 to 106:14]** Speculation; Lack of Foundation; Vague; Calls for Expert Opinion	**Re: [106:02 to 106:14]** The question is not vague nor does it lack foundation or call for expert testimony. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role, and the question specifically asks for his personal definition of a term ("your definition ....").
107:04 - 108:01 107:04 Did -- while you were at the Board, 107:05 did you recommend that physicians restrict their 107:06 patient to one pharmacy? 107:07 A. I think that was more from the Board of 107:08 Pharmacy than the Board of Medicine. 107:09 Q. Okay. 107:10 A. It was a way to try to curtail people 107:11 trying to gain prescriptions from different 107:12 pharmacies. You know, some -- some people would 107:13 get a prescription from one doctor and go to one 107:14 pharmacy and then go to another doctor and then go 107:15 to another pharmacy. 107:16 Q. Okay. Was that a problem -- 107:17 A. Yeah. 107:18 Q. -- in West Virginia? 107:19 A. It was. 107:20 Q. At any time, was this -- kind of go to a 107:21 doctor, go to different pharmacies to fill 107:22 prescriptions. At any time did that stop or 107:23 lessen? Was there a time period -- 107:24 A. I think with the monitoring program, it 108:01 certainly helped. I think that would be curtailed.	**Re: [107:04 to 108:01]** Calls for Expert Opinion; Speculation; Lack of Foundation; Vague (including time-frame)	**Re: [107:04 to 108:01]** Please see prior response. In addition, the timeframe is explicit in the question asked ("[W]hile you were at the board ...."). The question asks whether the deponent took a specific action, so could not call for speculation or require expert opinion.
109:06 - 109:24 109:06 Q. Okay. At some point, were board -- or 109:07 sorry, were licensees of the Board required to 109:08 obtain CME credits related to the administration of 109:09 naloxone? 109:10 A. Naloxone? 109:11 Q. Yeah. 109:12 A. I think there was. 109:13 Q. Okay. Do you know why the Board would 109:14 require licensees to take CME credits related to 109:15 naloxone? 109:16 A. Just because of the amount of overdoses 109:17 that were occurring through the use of prescribed 109:18 medications and, later, nonprescribed medications 109:19 as well. 109:20 Q. So was the CME kind of training on the 109:21 administration of naloxone? 109:22 A. Yes. It -- which is a rather simple 109:23 procedure -- 109:24 Q. Okay.		
110:01 - 110:08 110:01 A. -- for the administration of it. But they 110:02 should be aware of how to do it and that it's 110:03 available.		

Designations	Objections	Reponses
110:04 Q. Do you think that it would help reduce 110:05 opioid overdoses if physicians were trained in the 110:06 administration of naloxone? 110:07 A. I think with the -- with the use of 110:08 naloxone, it was to prevent deaths.		
110:22 - 111:06 110:22 Q. Was -- during your time at the Board, was 110:23 it entirely self-funded? 110:24 A. Yes. We -- it's just basically license 111:01 fees. And that's -- that's it. 111:02 Q. And renewal fees? 111:03 A. Yes. But the fines, you know, go to the 111:04 general fund. The Board of Medicine does not gen 111:05 -- benefit from the fines that they impose on 111:06 people.	**Re: [110:22 to 111:06]** Relevance	**Re: [110:22 to 111:06]** The question is relevant to how the Board of Medicine is funded and its potential incentives regarding licensing fees and disciplinary fees.
111:09 - 111:15 111:09 Q. So the Board of Medicine -- excuse me -- 111:10 does not receive any money from the City of 111:11 Huntington, correct? 111:12 A. Correct. 111:13 Q. And the Board of Medicine does not receive 111:14 any money from Cabell County, correct? 111:15 A. Correct.	**Re: [111:09 to 111:15]** Relevance	**Re: [111:09 to 111:15]** Please see prior response.
112:04 - 112:24 112:04 Q. Earlier when we were discussing the paper 112:05 that had been republished in the newsletter, it 112:06 talked about an opioid epidemic. Do you believe 112:07 that West Virginia had an opioid epidemic? 112:08 A. Yes, I do. 112:09 Q. Do you know when it began? 112:10 A. I think it began probably in the mid '90s. 112:11 They used to refer to it as "hillbilly heroin," the 112:12 use of oxycodone and OxyContin. And it just began 112:13 -- it just continued to increase since then. 112:14 Q. Do you believe West Virginia still has an 112:15 opioid epidemic? 112:16 A. I couldn't say. I have not kept track of 112:17 the records. I no longer live in West Virginia, 112:18 so, you know, I've had little to no contact with 112:19 the Board of Medicine since I left. 112:20 Q. Did West Virginia have an opioid epidemic 112:21 in 2016 when you were still at the Board? 112:22 A. Yes. 112:23 Q. Do you believe that Cabell County had an 112:24 opioid epidemic?		
113:01 - 113:24 113:01 A. Yes, I do. 113:02 Q. Do you know when that began? 113:03 A. No. I think along with other portions of 113:04 the state, it just increased and increased. I know 113:05 that Wayne County had some real marked issues years 113:06 prior to 2016. 113:07 Q. Do you believe that the City of Huntington 113:08 had an opioid epidemic? 113:09 A. I believe their citizens did, yes. 113:10 Q. Do you believe that inappropriate 113:11 prescribing contributed to the opioid epidemic? 113:12 A. I think in part, yes. 113:13 Q. Do you believe that doctor shopping 113:14 contributed to the opioid epidemic? 113:15 A. Yes. 113:16 Q. Do you believe that drug cartels 113:17 contributed to the opioid epidemic? 113:18 A. Define "cartel." 113:19 Q. You were talking about the oversea 113:20 drug-related -- 113:21 A. No. No, I don't think from a criminal 113:22 standpoint. There was not -- I think there's some		

Designations	Objections	Reponses
113:23 -- some issue of crime involved with -- with any 113:24 addictive drug. But I don't think they were the		
114:01 - 114:19 114:01 main push for the -- for the epidemic. 114:02 Q. Okay. What do you think the main push for 114:03 the epidemic was? 114:04 A. I think the amount of addiction that 114:05 occurred through people gaining opioids through 114:06 whatever means they could. 114:07 Q. Including doctors prescribing it to them? 114:08 A. Yes. 114:09 Q. Do you think the Board of Medicine bears 114:10 any responsibility for the opioid epidemic? 114:11 A. No. I don't think the Board of Medicine 114:12 did. Our efforts were to try to protect the public 114:13 and to provide education through the public and 114:14 physicians and to discipline those who were 114:15 inappropriately prescribing. 114:16 Q. So you believe that the Board did 114:17 everything that it could have. 114:18 A. I believe so, yeah. We tried hard. And 114:19 it's a -- it's a heart-wrenching concern.		
115:21 - 116:04 115:21 epidemic. And earlier, we had talked about pain 115:22 being treated as a fifth vital sign. Do you 115:23 believe that that contributed to the opioid 115:24 epidemic? 116:01 A. I think in a -- in a sense that it gave 116:02 some -- oh, I'm trying to think of the proper word. 116:03 -- basis for physicians to prescribe 116:04 in the manner that some of them did.	**Re: [115:21 to 116:04]** Speculation; Calls for Expert Opinion; Lack of Foundation; Vague	**Re: [115:21 to 116:04]** The question is not vague and expressly solicits Mr. Knittle's personal knowledge ("Do you believe ....") so does not lack foundation or call for speculation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. This question is within the personal knowledge he developed in that role and do not call for expert testimony.
116:05 - 116:14 116:05 Q. And do you believe that that manner was 116:06 overprescribing? 116:07 A. Yes. I think it was initially. 116:08 Q. Okay. Did the Board of Medicine undertake 116:09 any opioid-related initiatives to help combat the 116:10 opioid epidemic in West Virginia? 116:11 A. I think there was a concern over it and we 116:12 took steps legislatively and through education and 116:13 through discipline -- disciplining physicians and 116:14 P.A.'s, podiatrists.		
121:20 - 122:05 121:20 Q. Was the Board ever influenced by any drug 121:21 distributor to create a policy regarding the proper 121:22 use of opioids? 121:23 A. Not that I'm aware of, no. We had very 121:24 little contact with pharmaceutical -- as far as 122:01 pharmaceutical manufacturers. They would call us 122:02 now and then, offer us, you know, something that we 122:03 could download to say, "Don't use opioids 122:04 inappropriately" or something like that, but we had	**Re: [121:20 to 122:05]** Lack of Foundation; Speculation; Relevance; Vague	**Re: [121:20 to 122:05]** The question is not vague and does not call for speculation or lack foundation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia,

Designations		Objections	Reponses
122:05	very little contact with them whatsoever.		for 12 years. These questions are within the personal knowledge he developed in that role. The question is relevant to the board's operations, and to establish that defendants did not interact with the board regarding any policy related to prescribing.
122:18 - 122:21			
122:18	Q. Okay. So the drug distributors would not	**Re: [122:18 to 122:21]** Lack of Foundation; Speculation; Relevance; Vague	**Re: [122:18 to 122:21]** Please see prior response.
122:19	have influenced the Board of Medicine to create		
122:20	policies related to opioids.		
122:21	A. No, I don't believe so.		
123:09 - 124:14			
123:09	Q. As you sit here today, do you know of an	**Re: [123:09 to 124:14]** Relevance; Hearsay	**Re: [123:09 to 124:14]** Please see prior response. The testimony does not elicit hearsay as it does not seek for the witness to adopt the truth of any statements in the exhibit, but rather uses the exhibit for its notice to prescribers and its effect on prescribers' actions (through adopting of a piece of legislation that regulated prescribing activity). The standard of care and the State's regulation of prescribers are relevant.
123:10	instance where a wholesale drug distributor tried		
123:11	to approach a physician to influence the Board?		
123:12	A. I do not, no.		
123:13	Q. Okay. All right. Can you grab Tab 2?		
123:14	KNITTLE DEPOSITION EXHIBIT NO. 7		
123:15	(Management of Intractable Pain Act		
123:16	passed March 14, 1998 was marked for		
123:17	identification purposes as Knittle		
123:18	Deposition Exhibit No. 7.)		
123:19	A. Okay.		
123:20	Q. All right. This will be marked as Exhibit		
123:21	7 to your deposition, and it is the Management of		
123:22	Intractable Pain which was passed March 14th, 1998.		
123:23	Do you see that?		
123:24	A. Yes, I do.		
124:01	Q. Are you familiar with the Management of		
124:02	Intractable Pain Act?		
124:03	A. I had been, yes.		
124:04	Q. Okay. You go down to near the bottom.		
124:05	It's bold print, Section 30-3A-2, "Limitation on		
124:06	disciplinary sanctions or criminal punishment		
124:07	related to management of intractable pain."		
124:08	If you just want to read that Section		
124:09	A-1 and 2.		
124:10	A. Okay.		
124:11	Q. And so this is saying that the Board of		
124:12	Medicine could not discipline any licensees in the		
124:13	instances described in Section A-1 and 2. Correct?		
124:14	A. Yes.		
125:22 - 126:15			
125:22	Q. Okay. All right. If you want to grab Tab	**Re: [125:22 to 126:15]** Hearsay; Lack of Foundation; Speculation; Relevance; Vague (including time-period)	**Re: [125:22 to 126:15]** These questions are foundation-laying for the exhibit introduced and do not elicit hearsay. The Board of Medicine's adoption of a policy statement regarding the use of prescription opioids is relevant to issues in this case, including the standard of care. The time period is made express in the testimony (see 126:6-11).
125:23	3.		
125:24	KNITTLE DEPOSITION EXHIBIT NO. 8		
126:01	(Joint Policy Statement on Pain		
126:02	Management at the End of Life was		
126:03	marked for identification purposes as		
126:04	Knittle Deposition Exhibit No. 8.)		
126:05	A. Okay.		
126:06	Q. All right. This is going to be marked as		
126:07	Exhibit 8 to your deposition. It is the Joint		
126:08	Policy Statement on Pain Management at the End of		
126:09	Life. And if you turn to the last page, it says		
126:10	that it was approved by the West Virginia Board of		
126:11	Medicine March 12, 2001.		
126:12	A. Yes.		
126:13	Q. Are you aware of the Joint Policy Statement		
126:14	on Pain Management at the End of Life?		
126:15	A. Yes, I was aware of it.		
126:16 - 126:23			
126:16	Q. Okay. Do you know if the Board of Medicine		
126:17	was involved in the drafting of this?		

Designations	Objections	Reponses
126:18 A. I do not. I imagine they had -- they 126:19 probably had it placed before them in order to 126:20 approve it, and, you know, they could have -- they 126:21 may have offered suggestions as to language and 126:22 things, but I don't have any -- any recollection of 126:23 that. It was before I was there.		
126:24 - 128:06 126:24 Q. Okay. Do you know what the purpose of the 127:01 Joint Policy Statement On Pain Management At The 127:02 End of Life was? 127:03 A. I think because -- in order to use opioids 127:04 for the use of intractable pain with terminal 127:05 patients, in order to have a little more dignity in 127:06 death without unnecessary pain and suffering. 127:07 Q. On page 3 -- 127:08 A. Okay. 127:09 Q. -- the first paragraph, which is very 127:10 similar to the Position Statement in the Management 127:11 Of Intractable Pain, it says, "Health care 127:12 professionals should not fear disciplinary action 127:13 from the Boards for prescribing, administering, or 127:14 dispensing controlled substances, including opioid 127:15 analgesics, for a legitimate medical purpose and in 127:16 the usual course of professional practice. 127:17 All such prescribing must be 127:18 established with clear documentation of unrelieved 127:19 pain and in compliance with applicable state or 127:20 federal law." 127:21 So again, like we've discussed, you -- 127:22 the healthcare professionals should not fear 127:23 disciplinary action for prescribing opioids. 127:24 Right? 128:01 A. As long as they follow standard of care. 128:02 Q. Yeah. Because opioids can serve a 128:03 legitimate medical purpose. 128:04 A. They can, yes. Particularly with end of 128:05 life when there's not an issue of addiction with 128:06 someone who's terminally ill.	**Re: [126:24 to 128:06]** Hearsay; Lack of Foundation; Speculation; Relevance	**Re: [126:24 to 128:06]** These questions do not lack foundation or call for speculation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role. Mr. Knittle earlier testified that he was aware of the exhibit (126:13-15). Regulation of prescribers and the use of prescription opioids is relevant to this case, including to the standard of care. The question does not call for hearsay as it does not use any statement for the truth, but rather for notice of the relevant regulations passed by the State.
129:05 - 129:09 129:05 KNITTLE DEPOSITION EXHIBIT NO. 9 129:06 (Policy for the Use of Controlled 129:07 Substances for the Treatment of Pain 129:08 was marked for identification purposes 129:09 as Knittle Deposition Exhibit No. 9.)	**Re: [129:05 to 129:09]** Same objections as above	**Re: [129:05 to 129:09]** Please see prior response.
129:23 - 130:07 129:23 Q. So then if you turn to the next page, it 129:24 says that this is "Policy for the Use of Controlled 130:01 Substances for the Treatment of Pain, Effective 130:02 January 10, 2005." 130:03 Do you know if this was a replacement 130:04 to the 1997 Position Statement on the use of 130:05 opioids that we discussed earlier that was Exhibit 130:06 6? 130:07 A. I believe that it was.	**Re: [129:23 to 130:07]** Same objections as above	**Re: [129:23 to 130:07]** Please see prior response.

Designations	Objections	Reponses
130:16 - 130:24 130:16 Q. And was this policy used then to establish 130:17 the standard of care for licensees to follow or 130:18 abide by? 130:19 A. Yes, I think it was -- it was written in 130:20 order to be given some guidelines to go by. 130:21 Q. And by this, the Board was leaving the 130:22 decision to manage pain to the discretion of the 130:23 treating physician. Correct? 130:24 A. Yes. Yes.	**Re: [130:16 to 130:24]** Same objections as above	**Re: [130:16 to 130:24]** Please see prior response.
131:17 - 132:07 131:17 Q. Okay. And this policy was provided to 131:18 alleviate physician uncertainty and to encourage 131:19 better pain management, correct? 131:20 A. Yes. And I think, you know, in part too, 131:21 to curb the amount of use inappropriately of 131:22 opioids. 131:23 Q. And this policy has a paragraph, a last 131:24 paragraph, on page 1 very similar to the paragraphs 132:01 that we've read before about a physician shouldn't 132:02 fear disciplinary action from the Board? 132:03 So while it was the policy of the 132:04 Board in 1997, it continued to be the policy to 132:05 make sure its licensees didn't fear discipline for 132:06 just prescribing opioids, correct? 132:07 A. Correct.	**Re: [131:17 to 132:07]** Same objections as above	**Re: [131:17 to 132:07]** Please see prior response.
132:08 - 132:12 132:08 Q. Okay. And if a physician deviated from 132:09 this policy, they wouldn't automatically be 132:10 disciplined. Correct? 132:11 A. No. It would depend on the circumstances 132:12 of the patient.		
132:13 - 132:20 132:13 Q. Okay. I know you were only there for a 132:14 couple of weeks. But was the Board influenced by 132:15 any wholesale drug distributors to create this 132:16 policy? 132:17 A. I'm not aware of any. 132:18 Q. Okay. Do you know if they were influenced 132:19 by any drug manufacturers to create this policy? 132:20 A. I'm not aware of any.	**Re: [132:13 to 132:20]** Speculation; Lack of Foundation/Personal Knowledge; Relevance	**Re: [132:13 to 132:20]** The question does not call for speculation or lack foundation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role. The question is relevant to the board's operations, and to establish that defendants did not interact with the board regarding any policy related to prescribing.
132:21 - 133:03 132:21 Q. Okay. How would the Board let its 132:22 licensees know about the changes in the policy? 132:23 A. Oftentimes through the newsletter. 132:24 Q. Okay. 133:01 A. And later on, through the website. And to 133:02 sharing with other entities that the physicians 133:03 come in contact with.	**Re: [132:21 to 133:03]** Vague (including time-frame)	**Re: [132:21 to 133:03]** The question is not vague, and is asked of a deponent who served as the Board's executive director for twelve years. No form objection was made at the deposition and is waived.
133:17 - 135:21 133:17 KNITTLE DEPOSITION EXHIBIT NO. 10 133:18 (WVBOM Quarterly Newsletter, Volume 133:19 12, Issue 4, October-December 2008 was 133:20 marked for identification purposes as 133:21 Knittle Deposition Exhibit No. 10.) 133:22 A. Okay.	**Re: [133:17 to 135:21]** Hearsay; Relevance	**Re: [133:17 to 135:21]** The document has previously been admitted into evidence, and the questioning does not elicit hearsay as it asks for the deponent's

Designations		Objections	Reponses
133:23	Q. This will be marked as Exhibit 10 to your		understanding of why certain
133:24	deposition. It's the West Virginia Board of		actions were taken. The Board
134:01	Medicine Quarterly Newsletter, Volume 12, Issue 4,		of Medicine's guidance to
134:02	October through December of 2008. Correct?		prescribers regarding
134:03	A. Yes.		prescribing opioids is
134:04	Q. Okay. Could you turn to page 6?		relevant to this case,
134:05	A. Okay.		including to the standard of
134:06	Q. All right. The bottom part of the page		care.
134:07	says, "Responsible Opioid Prescribing: A		
134:08	Physician's Guide; Now Available For Online		
134:09	Purchase."		
134:10	And it says that "In the Spring of		
134:11	2008, the Board of Medicine, in conjunction with		
134:12	the Federation of State Medical Boards and the		
134:13	Health and Human Services Committee on Substance		
134:14	Abuse Treatment," "was able to distribute this book		
134:15	to every licensed physician and physician assistant		
134:16	in West Virginia."		
134:17	And it says it's a "150-page book by		
134:18	pain expert Scott Fishman, M.D." Do you know why		
134:19	the Board of Medicine distributed this guide to all		
134:20	of its licensees?		
134:21	A. I think the amount of addiction and deaths		
134:22	due to opioids continued to increase, and the		
134:23	Federation of State Medical Boards had worked with		
134:24	Scott Fishman, who -- in his work in California,		
135:01	and he produced this book and distributed it free		
135:02	of charge to people.		
135:03	Q. Okay.		
135:04	A. In fact, he didn't benefit financially from		
135:05	the book at all.		
135:06	Q. Did the Board think that the book was a		
135:07	good book to guide physicians on how to responsibly		
135:08	prescribe opioids?		
135:09	A. Yes, it was.		
135:10	Q. And the newsletter states that "the		
135:11	response to the book has been quite positive." Do		
135:12	you know what that meant?		
135:13	A. I think people -- I think physicians found		
135:14	it helpful to gain a better understanding of		
135:15	opioids, the dangers of them and how to best		
135:16	prescribe them and what circumstances.		
135:17	Q. Okay. Was the Board influenced by any		
135:18	wholesale drug distributors to distribute this		
135:19	book?		
135:20	A. No. It came through the Federation of		
135:21	State Medical Boards.		
135:22 - 136:01			
135:22	Q. Okay. Was the Board influenced by any drug		
135:23	manufacturers to distributor this book?		
135:24	A. No. Again, it was through the medical		
136:01	board, the FSMB.		
136:02 - 136:23			
136:02	Q. Okay. Besides the response being quite	**Re: [136:02 to 136:23]**	**Re: [136:02 to 136:23]**
136:03	positive, do you recall any comments or information	Same objections as	The document has
136:04	from any of the licensees regarding the book	above	previously been admitted into
136:05	itself?		evidence, and the questioning
136:06	A. The book? No, other than that the people		does not elicit hearsay as it
136:07	that had read it felt that it was beneficial to		asks for the deponent's
136:08	them. We actually had -- Scott Fishman presented		understanding of why certain
136:09	at the Federation of Medical -- State Medical		actions were taken. The Board
136:10	Boards at one of their national conventions, and		of Medicine's guidance to
136:11	one of his biggest concerns was the death rate and		prescribers regarding
136:12	the amount of addiction in West Virginia.		prescribing opioids is
136:13	So we asked him to come and speak to		relevant to this case,
136:14	us, and we had Doctor Fishman come to West Virginia		including to the standard of
136:15	and, you know, through the physicians health		care.
136:16	program and be a speaker for several hundred		
136:17	people, which was very helpful.		

Designations	Objections	Reponses
136:18 Q. Do you recall when that was? 136:19 A. No, I think it was after the book was 136:20 published. 136:21 Q. Okay. 136:22 A. What year was this? 136:23 Q. It was spring of 2008.		
137:14 - 137:22 137:14 Q. Were licensees of the Board invited to 137:15 attend -- 137:16 A. Yeah. 137:17 Q. -- Mr. Fishman's presentation? Okay. 137:18 A. They were. 137:19 Q. Did they receive any continuing education 137:20 credits to attend? 137:21 A. I believe it was managed through the 137:22 physicians health program that they did.	**Re: [137:14 to 137:22]** Speculation; Lack of Foundation/Personal Knowledge; Relevance	**Re: [137:14 to 137:22]** The question does not call for speculation, nor does it lack foundation or personal knowledge. Mr. Knittle was the Executive Director of the Board of Medicine for twelve years, and is testifying from his personal knowledge in responding to these questions. Questions related to the standard of care and the Board of Medicine's guidance surrounding use of prescription opioids are relevant.
138:12 - 142:21 138:12 Q. All right. Will you pull out Tab 11? 138:13 KNITTLE DEPOSITION EXHIBIT NO. 11 138:14 (Management of Pain Act passed April 138:15 8, 2009 was marked for identification 138:16 purposes as Knittle Deposition Exhibit 138:17 No. 11.) 138:18 A. Okay. 138:19 Q. All right. And this will be marked as 138:20 Exhibit 11 to your deposition, and this is the 138:21 Management of Pain Act passed April 8th, 2009. Do 138:22 you see that? 138:23 A. Uh-huh. Yes, I do. 138:24 Q. Okay. And this looks to be kind of an 139:01 iteration or an update of the legislation we 139:02 discussed earlier that was Exhibit 7. 139:03 A. Yes. 139:04 Q. Are you familiar with the Management of 139:05 Pain Act? 139:06 A. Yes. I think this was an amended version 139:07 of the previous one. 139:08 Q. Okay. Did the Board of Medicine have any 139:09 involvement in the drafting of the Management of 139:10 Pain Act? 139:11 A. I think we probably were cognizant of it as 139:12 it was being amended and probably had some level of 139:13 thumbs up or thumbs down on it or modification. 139:14 Q. But the Board itself wouldn't write the 139:15 text of it. It would kind of be presented to the 139:16 Board to say, "Do you agree with this"? 139:17 A. Yeah. I don't think it was initiated by 139:18 us. I think it was in -- it was the legislature 139:19 and -- yeah, legislators who prompted it. 139:20 Q. Okay. If you compare it to the 1998 one, 139:21 the title of it is a little bit different. The 139:22 1998 one says "Management of Intractable Pain" and 139:23 the 2009 version is just "Management of Pain Act."	**Re: [138:12 to 142:21]** Improper narrative; Hearsay; Relevance; Lack of Foundation/Personal Knowledge	**Re: [138:12 to 142:21]** The question does not lack foundation or personal knowledge. Mr. Knittle was the Executive Director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role. Mr. Knittle testified that the Board was "cognizant" of the law (139:11). The question does not call for hearsay as it refers to legislation passed by the State, which provides notice to the regulated parties. Regulation of prescribers is relevant to this case.

Designations		Objections	Reponses
139:24	A. Uh-huh.		
140:01	Q. And if you look at the definition -- do you		
140:02	have the 1998 version in front of you too?		
140:03	A. No, I don't.		
140:04	Q. Could you grab that one?		
140:05	A. Okay. Which tab was it?		
140:06	Q. It was Tab 2.		
140:07	A. Okay.		
140:08	Q. If you look at the definition of		
140:09	"Intractable pain" in the 1998 version -- just read		
140:10	that over. It's number (3) in the first -- under		
140:11	Article 3A.		
140:12	A. Yes, I have it.		
140:13	Q. Okay.		
140:14	A. So that's intractable pain in the '98		
140:15	version?		
140:16	Q. And then if you look at the 2009 version,		
140:17	there is no definition for intractable pain, but		
140:18	there is a definition for "pain."		
140:19	A. Yes.		
140:20	Q. Okay. And the definition of "pain" in the		
140:21	2009 version is "'Pain' means an unpleasant sensory		
140:22	and emotional experience associated with actual or		
140:23	potential tissue damage or described in terms of		
140:24	such damage."		
141:01	If you compare the definitions of		
141:02	"intractable pain" versus just "pain," would you		
141:03	agree with me that the definition of "pain" is a		
141:04	bit broader than the definition of "intractable		
141:05	pain"?		
141:06	A. Yes, it is.		
141:07	Q. Because "intractable pain" definition must		
141:08	have a "cause that cannot be removed" and "pain"		
141:09	does not have such language in its definition.		
141:10	A. Right.		
141:11	Q. Okay. And when you compare the two -- the		
141:12	1998 version and the 2009 version, they are		
141:13	virtually identical except for the 1998 version		
141:14	will use the term "intractable pain" and the 2009		
141:15	will use the term "pain."		
141:16	Do you agree with me?		
141:17	A. I didn't go through letter by letter --		
141:18	Q. Okay.		
141:19	A. -- but you say that they're exactly		
141:20	identical?		
141:21	Q. Nearly identical, yes.		
141:22	A. All right.		
141:23	Q. Okay. And in fact, the section on the 1998		
141:24	version that we reviewed, the 30-3A-2(a)(1) and		
142:01	(2) --		
142:02	A. Yeah.		
142:03	Q. -- is virtually identical. I think they --		
142:04	one says "a physician shall not be subject" and the		
142:05	other one "a physician is not subject." But other		
142:06	than that, the definitions of "pain" versus		
142:07	"intractable pain" is exactly the same.		
142:08	A. Okay.		
142:09	Q. So again, it would have been the position		
142:10	of the Board of Medicine in 2009 that a physician		
142:11	shall not or should not fear disciplinary action		
142:12	just for prescribing opioids, correct?		
142:13	A. Yeah, for the management of pain.		
142:14	Q. And how would the Board of Medicine inform		
142:15	its licensees of the change in the legislation?		
142:16	A. Through newsletter. And through		
142:17	distribution with the other entities.		
142:18	Q. Okay. Was the Board of Medicine influenced		
142:19	by any wholesale drug distributor related to the		
142:20	creation of this 2009 legislation?		
142:21	A. Not that I'm aware of, no.		

Designations	Objections	Reponses
142:22 - 143:01 142:22 Q. Okay. Was the Board of Medicine influenced 142:23 by any drug manufacturer related to the 2009 142:24 legislation? 143:01 A. Not that I'm aware of, no.	**Re: [142:22 to 143:01]** Same objections as above; Also, objection to overlapping designations	**Re: [142:22 to 143:01]** The question does not lack foundation or personal knowledge. Mr. Knittle was the Executive Director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role. Mr. Knittle testified that the Board was "cognizant" of the law (139:11). The question does not call for hearsay as it refers to legislation passed by the State, which provides notice to the regulated parties. Regulation of prescribers is relevant to this case. Designation modified to avoid overlap.
143:02 - 143:23 143:02 Q. Okay. All right. Can you grab Tab 15? 143:03 KNITTLE DEPOSITION EXHIBIT NO. 12 143:04 (Joint Policy Statement on Pain 143:05 Management at the End of Life was 143:06 marked for identification purposes as 143:07 Knittle Deposition Exhibit No. 12.) 143:08 A. Did you say 15 or 16? 143:09 Q. 15. 143:10 A. Okay. 143:11 Q. All right. And this will be marked as 143:12 Exhibit 12 to your deposition, and it is the Joint 143:13 Policy Statement on Pain Management at the End Of 143:14 Life, and if you turn to page 4, it says that it 143:15 was originally adopted March 12th, 2001 and 143:16 re-adopted May 10th, 2001 by the West Virginia 143:17 Board of Medicine. Do you see that? 143:18 A. Yes, I do. 143:19 Q. Okay. So this is -- appears to be exactly 143:20 the same Joint Policy Statement on Pain Management 143:21 at the End of Life that we discussed earlier that 143:22 was Exhibit 8? 143:23 A. Yes.	**Re: [143:02 to 143:23]** Relevance; Hearsay	**Re: [143:02 to 143:23]** The document and questions are not hearsay as they are relevant to prescriber behavior and are offered for their effect on prescribers, not for the truth of statements therein.
145:06 - 145:09 145:06 Q. Was the Board influenced by any wholesale 145:07 drug distributors to relook at all of its policies 145:08 during this time? 145:09 A. No.	**Re: [145:06 to 145:09]** Lack of Foundation/Personal Knowledge; Speculation; Relevance	**Re: [145:06 to 145:09]** This question does not lack foundation or call for speculation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. The question is relevant to the board's operations, and to establish that defendants did not interact with the board regarding any policy related to prescribing.

Designations	Objections	Reponses
145:22 - 147:06 145:22 KNITTLE DEPOSITION EXHIBIT NO. 13 145:23 (Policy for the Use of Controlled 145:24 Substances for Treatment of Pain dated 146:01 May 10, 2010 was marked for 146:02 identification purposes as Knittle 146:03 Deposition Exhibit No. 13.) 146:04 A. Okay. I have it. 146:05 Q. And this exhibit will be marked as Exhibit 146:06 13 to your deposition and the number on the bottom 146:07 of the first page is WV_BOM00001291. And if you 146:08 turn to the second page, it says it's the Policy 146:09 for the Use of Controlled Substances for Treatment 146:10 of Pain. 146:11 And similar to the policy that we just 146:12 looked at, if you go to the last page, this is also 146:13 re-adopted on May 10th, 2010 by the Board of 146:14 Medicine. And this appears to be identical to the 146:15 policy from 2005 that we discussed earlier. 146:16 Is this the same situation of the other 146:17 one, it was just the Board was looking at 146:18 everything it had, and if it agreed with the 146:19 language, it re-adopted it; if it needed to change 146:20 anything, they would change the language. 146:21 A. Yes. I think if you look at all of our 146:22 policies for that time period, over a course of a 146:23 couple of meetings, we went through all our 146:24 policies. 147:01 Q. Okay. So it would have been the position 147:02 of the Board in -- that its Policy for the Use of 147:03 Controlled Substances for the Treatment of Pain did 147:04 not need to change at all from January of 2005 to 147:05 May of 2010. 147:06 A. Right.	**Re: [145:22 to 147:06]** Compound; Improper Narrative; Relevance; Speculation; Lack of Foundation	**Re: [145:22 to 147:06]** The questioning is not compound and constitutes preliminary questions laying a foundation for a document just introduced. The document is not used for the truth of its contents, and the deponent has personal knowledge and the ability to testify about the document, as it was a Board of Medicine policy adopted during his tenure as Executive Director of the board.
148:23 - 149:06 148:23 Did the Board of medicine ever 148:24 promulgate rules for the licensure of pain 149:01 management clinics? 149:02 A. I believe they did, yes. 149:03 Q. Okay. Do you know what they were? 149:04 A. No. I know that we had to monitor them and 149:05 that there were certain stipulations that they had 149:06 to abide by.	**Re: [148:23 to 149:06]** Relevance; Lack of Foundation/Personal Knowledge; Scope	**Re: [148:23 to 149:06]** The question does not lack foundation or personal knowledge. Mr. Knittle was the Executive Director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. These questions are within the personal knowledge he developed in that role. The scope objection is unfounded as this was a fact deposition, and in any case the questions relate to the deponent's personal knowledge as Executive Director of the Board of Medicine.
153:20 - 154:04 153:20 Q. What did the Board do to designate a person 153:21 to access the CSMP database? 153:22 A. I recommended to the Board that our 153:23 investigator be the lead person for -- to access 153:24 it. 154:01 Q. And did the Board accept that 154:02 recommendation? 154:03 A. I believe they did, yes. I did not have 154:04 access to it.	**Re: [153:20 to 154:04]** Speculation; Lack of Foundation/Personal Knowledge; Relevance	**Re: [153:20 to 154:04]** Please see prior response.

Designations	Objections	Reponses
158:24 - 159:05 158:24 KNITTLE DEPOSITION EXHIBIT NO. 15 159:01 (Model Policy on the Use of Opioid 159:02 Analgesics in the Treatment of Chronic 159:03 Pain was marked for identification 159:04 purposes as Knittle Deposition Exhibit 159:05 No. 15.)	**Re: [158:24 to 159:05]** Hearsay; Relevance	**Re: [158:24 to 159:05]** The document has previously been admitted into evidence, and the questioning does not elicit hearsay as it asks for the deponents' understanding of what the policy is, it does not offer the contents of the policy for truth. Guidance to prescribers regarding prescribing opioids is relevant to this case, including to the standard of care.
159:09 - 159:19 159:09 Q. All right. And this will be marked as 159:10 Exhibit 15 to your deposition. Do you recognize 159:11 this document? 159:12 A. I do. 159:13 Q. Okay. And what is it? 159:14 A. It's the policy for the use of opioid 159:15 analgesics for the treatment of chronic pain that 159:16 was put out by the Federation of State Medical 159:17 Boards. 159:18 Q. And it's dated July 2013? 159:19 A. It is.	**Re: [159:09 to 159:19]** Hearsay; Relevance	**Re: [159:09 to 159:19]** Please see prior response.
162:09 - 162:12 162:09 Q. Do you know if FSMB was influenced in any 162:10 way by any wholesale drug distributors to create 162:11 the 2013 model policy? 162:12 A. No, I do not.	**Re: [162:09 to 162:12]** Lack of Foundation; Speculation; Relevance; Vague	**Re: [162:09 to 162:12]** This question is not vague and does not lack foundation or call for speculation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. The question is relevant to the board's operations, and to establish that defendants did not interact with the board regarding any policy related to prescribing.
162:18 - 163:09 162:18 KNITTLE DEPOSITION EXHIBIT NO. 16 162:19 (WVBOM Policy on the Use of Opioid 162:20 Analgesics in the Treatment of Chronic 162:21 Pain was marked for identification 162:22 purposes as Knittle Deposition Exhibit 162:23 No. 16.) 162:24 A. Okay. 163:01 Q. All right. So this says these are the 163:02 Board of Medicine's Policy on the Use of Opioid 163:03 Analgesics in the Treatment of Chronic Pain and 163:04 dated July 2013. And it says they are adopted from 163:05 the model policy guidelines of the Federation of 163:06 State Medical Boards. 163:07 Would those be the July -- the July 163:08 policy that we just talked about? 163:09 A. Yes.	**Re: [162:18 to 163:09]** Compound; Hearsay;	**Re: [162:18 to 163:09]** The document has previously been admitted into evidence, and the questioning does not elicit hearsay as it asks for the deponents' understanding of what the policy is, and therefore it does not offer the contents of the policy for truth. Guidance to prescribers regarding prescribing opioids is relevant to this case, including to the standard of care.
163:15 - 163:20 163:15 Q. Do you know if the Board made any changes 163:16 to the FSMB model policy? 163:17 A. I don't believe that they did. I know that 163:18 they reviewed it carefully, it being a new policy 163:19 with a lot more information in it, but I don't	**Re: [163:15 to 163:20]** Lack of Foundation/Personal Knowledge; Speculation; Relevance	**Re: [163:15 to 163:20]** This question does not lack foundation or call for speculation. Mr. Knittle was the executive director for

Designations		Objections	Reponses
163:20	think they made any policy -- any changes in it.		the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. The question is relevant to the board's operations and policies impacting the standard of care.
164:03 - 164:13			
164:03	Q. What was the purpose of the Board adopting	**Re: [164:03 to 164:13]**	**Re: [164:03 to 164:13]**
164:04	the Policy on the Use of Opioid Analgesics in the	Same objections as	Please see prior
164:05	Treatment of Chronic Pain?	above	response.
164:06	A. I think it was to have a -- just a common		
164:07	understanding across the nation as to how -- how		
164:08	you should use opioid analgesics for the treatment		
164:09	of chronic pain. We wanted to try to get it as		
164:10	uniform as possible from state to state in terms of		
164:11	language and expectation of physicians.		
164:12	You know, moving from, you know, West		
164:13	Virginia to Texas to South Dakota to California.		
164:18 - 165:05			
164:18	Q. All right. The second, I guess, full	**Re: [164:18 to 165:05]**	**Re: [164:18 to 165:05]**
164:19	paragraph - even though it's only a sentence - says	Same objections as	Please see prior
164:20	"The CSA does not limit the amount of drug	above	response.
164:21	prescribed, the duration for which it is		
164:22	prescribed, or the period for which a prescription		
164:23	is valid (although some states do impose such		
164:24	limits)."		
165:01	Do you know if West Virginia imposes		
165:02	limits?		
165:03	A. No, we did not. We didn't cap anything.		
165:04	I'm trying to think of a state that did, and I		
165:05	can't recall one.		
166:04 - 166:19			
166:04	Q. And during your tenure at the Board, did		
166:05	the Board have licensees that illegally prescribed		
166:06	opioids?		
166:07	A. Yeah, there were a number of them that		
166:08	ended up being criminally prosecuted.		
166:09	Q. Okay. And what was their criminal intent?		
166:10	A. I believe that their intent was -- was		
166:11	financial in nature.		
166:12	Q. Okay. Do you know of any board licensees		
166:13	that illegally prescribed in Cabell County?		
166:14	A. I believe that there were. I can't give		
166:15	you their names. And there were some that		
166:16	prescribed in Cabell County and other counties,		
166:17	surrounding counties, as well.		
166:18	But there were some that -- that were		
166:19	criminal in their -- in their actions.		
167:14 - 167:21			
167:14	Q. Okay. Was the Board of Medicine influenced		
167:15	in any way by any wholesale drug distributors to		
167:16	adopt the policy on the use of opioid analgesics in		
167:17	the treatment of chronic pain?		
167:18	A. No.		
167:19	Q. Was the Board influenced by any		
167:20	manufacturers?		
167:21	A. Not that I'm aware of.		

Designations	Objections	Reponses
168:10 - 168:24 168:10 Q. All right. This will be marked as Exhibit 168:11 17 to your deposition. And it is the West Virginia 168:12 Board of Medicine Quarterly Newsletter, Volume 17, 168:13 Issue 3, July through September of 2013. Correct? 168:14 A. Yes, it is. 168:15 Q. Okay. On page 2, it says, "Update On Board 168:16 Policies." So is this kind of like how we talked 168:17 about for many of the other policies, that the 168:18 Board would put information in the newsletter about 168:19 changes in policies? 168:20 A. Yes. 168:21 Q. And so this one is talking about the Policy 168:22 on the Use of Opioid Analgesics in the Treatment of 168:23 Chronic Pain. And that would be Exhibit 16 that we 168:24 just discussed. Right?		
169:01 - 169:24 169:01 A. Yes. 169:02 Q. Okay. And the second full paragraph, the 169:03 first sentence, says, "The Board continues 169:04 overtreatment and the continued use of ineffective 169:05 treatments to be the most common and problematic 169:06 iterations of the inappropriate treatment of pain." 169:07 What is "overtreatment"? 169:08 A. "Overtreatment" would be overprescribing, 169:09 prescribing multiple medications. 169:10 Q. And what is the "continued use of 169:11 ineffective treatments"? 169:12 A. To continue a treatment regimen that is 169:13 ineffective. 169:14 Q. What options would a prescriber have if 169:15 opioid therapy was ineffective? 169:16 A. I think there's a number of them. I 169:17 couldn't tell you, again, not being a physician. I 169:18 know that there are some good pain management 169:19 specialists out there who have developed pain 169:20 management without the use of opioids and have had 169:21 good success with it. 169:22 So I think they had to begin to look 169:23 at other options. 169:24 Q. Why were these the most common and		
170:01 - 170:13 170:01 problematic iterations of the inappropriate 170:02 treatment of pain in 2013? 170:03 A. I think probably we were looking at the 170:04 complaints and things we had that people were 170:05 overprescribing; people continued to provide 170:06 opiates at higher dosages although there was no 170:07 indication that there was any effectiveness 170:08 whatsoever. 170:09 And more information was coming out 170:10 that opioids often do not control pain very well. 170:11 Q. Where was that information coming from? 170:12 A. I believe it was coming from medical 170:13 associations, medical journals across the nation.		
178:07 - 180:01 178:07 KNITTLE DEPOSITION EXHIBIT NO. 21 178:08 (WV Legislature 2016 Regular Session 178:09 Enrolled Senate Bill 627 was marked 178:10 for identification purposes as Knittle 178:11 Deposition Exhibit No. 21.) 178:12 A. Okay. 178:13 Q. All right. This may look familiar, but 178:14 this will be marked as Exhibit 21 to your 178:15 deposition. And if -- the front says it's passed 178:16 March 10th, 2016, and if you turn to the next page, 178:17 it's the Management of Intractable Pain Act. 178:18 A. Yes.	**Re: [178:07 to 180:01]** Hearsay; Compound; Lack of Foundation/Personal Knowledge; Speculation; Relevance	**Re: [178:07 to 180:01]** This question does not lack foundation or call for speculation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. The question is relevant to the board's operations and policies impacting the standard of

Designations		Objections	Reponses
178:19	Q. So we have previously discussed two prior		care. The questioning does not
178:20	versions of this, the 1998 and the 2009 versions,		elicit hearsay as it asks for
178:21	correct?		the deponents' understanding
178:22	A. Yes.		of what the policy is, it does
178:23	Q. Was the Board involved in the drafting of		not offer the contents of the
178:24	this 2016 version?		policy for truth. Guidance to
179:01	A. I believe we were, but I don't recall the		prescribers regarding
179:02	circumstances of it. There was a -- there was a		prescribing opioids is
179:03	reason why it was -- it was moot -- or it was -- or		relevant to this case,
179:04	amended.		including to the standard of
179:05	Q. Okay. And if you look on the second page,		care.
179:06	the top paragraph, says, "An Act to amend and		
179:07	reenact Section 30-3A-2 of the Code of West		
179:08	Virginia, 1931, as amended; and to amend and		
179:09	reenact Section 55-7-23 of said code, all relating		
179:10	to permitting physicians to decline prescribing		
179:11	controlled substance in certain circumstances;		
179:12	limiting disciplinary action by a licensing board		
179:13	on a health care provider with prescriptive		
179:14	authority for declining to prescribe, or declining		
179:15	to continue to prescribe, any controlled substance		
179:16	in certain circumstances and providing that a		
179:17	health care provider with prescriptive authority is		
179:18	not liable to a patient or third party for		
179:19	declining to prescribe, or declining to continue to		
179:20	prescribe, any controlled substance in certain		
179:21	circumstances."		
179:22	So the amendment seems to be trying to		
179:23	address the issue where a physician was declining		
179:24	to prescribe a controlled substance.		
180:01	A. Yes.		
181:23 - 182:05			
181:23	Q. And prior to this amendment, if the Board	**Re: [181:23 to 182:05]**	**Re: [181:23 to 182:05]**
181:24	had received a complaint regarding a physician not	Lack of	This question does
182:01	prescribing opioids, would the Board have	Foundation/Personal Knowledge;	not lack foundation or call
182:02	disciplined that physician?	Speculation; Relevance	for speculation. Mr. Knittle
182:03	A. I think we would looked -- would have		was the executive director for
182:04	looked into the complaint to see if there was any		the WV Board of Medicine, one
182:05	merit.		of the primary regulators of
			prescribers in West Virginia,
			for 12 years. The question is
			relevant to the board's
			operations and policies
			regarding prescriber
			discipline.
191:17 - 193:20			
191:17	Q. And how did the Board try to identify the	**Re: [191:17 to 193:20]**	**Re: [191:17 to 193:20]**
191:18	prescribers who were contributing to the alarming	Vague; Relevance	The question is not
191:19	and sad situation?		vague and is relevant to the
191:20	A. Through complaints. We can't go fishing --		Board of Medicine's policies
191:21	you can't go into the CSMP and start looking and		regarding investigating
191:22	saying, "Oh, okay, who's the biggest prescribers		prescriber behavior.
191:23	here?" That's, you know, grossly illegal, and it		
191:24	was not the purpose of the CSMP, and there was a		
192:01	lot of caution against that kind of activity where		
192:02	they could -- that information could be used		
192:03	detrimentally towards people.		
192:04	So, you know, we function by		
192:05	complaints, the complaint process, and we really		
192:06	can't -- are not authorized to do anything unless		
192:07	there's a complaint.		
192:08	Q. And why would just going into the CSMP - if		
192:09	you had the ability - to say, "Who's the biggest		
192:10	prescriber," why wouldn't that do anything for you?		
192:11	I mean, would you have wanted to be able to do		
192:12	that?		
192:13	A. No. No. And it would not be for -- for		
192:14	the Board of Medicine. It would be for law		
192:15	enforcement. That -- you know, if they have a --		

Designations		Objections	Reponses
192:16	someone under suspicion, they can't pull up that		
192:17	information and then say, "Oh, okay, well, so-and-		
192:18	so's -- you know, look at this, you know, he has		
192:19	two different doctors prescribing to him, let's --		
192:20	let's monitor him and then pick it up."		
192:21	You know, which is illegal. So -- or		
192:22	people using it to get information against		
192:23	somebody. You know, there was an instance of --		
192:24	that I had heard of where someone had found		
193:01	information on their ex-wife. So, you know, that's		
193:02	a -- you can -- you can use it -- you can use it in		
193:03	a lot of criminal ways, and there was a great deal		
193:04	of effort to make sure that that didn't happen.		
193:05	Q. And just going in and getting information		
193:06	on the biggest prescriber wouldn't tell you		
193:07	anything. The biggest prescriber could be working		
193:08	in hospice where it's end-of-life care and of		
193:09	course they're the biggest prescriber --		
193:10	A. Right.		
193:11	Q. -- that type of situation.		
193:12	A. Right.		
193:13	Q. The numbers --		
193:14	A. That was just a -- that was just a, you		
193:15	know, a possibility, throw it out in the air.		
193:16	Q. Yeah.		
193:17	A. But you know, you're exactly right.		
193:18	Q. Yeah. The numbers alone don't tell you		
193:19	anything.		
193:20	A. Right.		
193:21 - 194:22			
193:21	Q. Okay. Can you pull out Tab 36?	**Re: [193:21 to 194:22]**	**Re: [193:21 to 194:22]**
193:22	KNITTLE DEPOSITION EXHIBIT NO. 42	Compound; Hearsay;	The questioning is
193:23	(WVBOM June 2016 Newsletter was marked	Relevance	not compound and constitutes
193:24	for identification purposes as Knittle		preliminary questions laying a
194:01	Deposition Exhibit No. 24.)		foundation for a document just
194:02	A. Okay.		introduced. The document is
194:03	Q. Perfect. This will be marked as Exhibit 24		not used for the truth of its
194:04	to your deposition. And this is the June 2016 West		contents, but for the Board of
194:05	Virginia Board of Medicine newsletter, correct?		Medicine's belief (see
194:06	A. Yes.		194:18-21). The Board's
194:07	Q. And if you turn to page 6.		understanding of the causes of
194:08	A. Okay.		opioid misuse and abuse is
194:09	Q. The title is "Reducing Risk:		relevant, including to
194:10	Opioid-Prescribing Guideline Developed by CDC."		standard of care.
194:11	And the first full paragraph states, "Since 2006,		
194:12	West Virginia has been the epicenter for		
194:13	prescription drug overdose deaths in the nation.		
194:14	This primarily has been fueled by the liberal		
194:15	prescription of opioids over the past decade,		
194:16	unfortunately compounded by overdose deaths from		
194:17	heroin and illicitly-produced fentanyl."		
194:18	So in -- in at least 2016, it was the		
194:19	Board's belief that the opioid epidemic was		
194:20	primarily fueled by doctors liberally prescribing		
194:21	opioids, correct?		
194:22	A. Yes.		
196:07 - 196:24			
196:07	Q. For -- I'm sorry. For all of the	**Re: [196:07 to 196:24]**	**Re: [196:07 to 196:24]**
196:08	guidelines that we've discussed, including the	Relevance	The Board of
196:09	adoption of the 2013 FSMB guidelines, the Board		Medicine's policies and
196:10	would have relied on the judgment of the medical		actions in relation to
196:11	professionals on the Board as to whether to accept		providing guidance to
196:12	or adopt those guidelines, correct?		prescribers, including sources
196:13	A. Yes.		of potential influence for
196:14	Q. Okay. And when the Board adopted the FSMB		that guidance, is relevant to
196:15	2013 guidelines, did they make that decision		the standard of care. Issues
196:16	independent from the FSMB, or did the FSMB request		of prescribing and Board of
196:17	that the Board adopt the guidelines?		Medicine regulation thereof
196:18	A. No, it was -- it was their own independent		have been affirmatively

Designations	Objections	Reponses
196:19 decision. You know, the guidelines were put out by 196:20 the FSMB, but there was no coercion on anyone's 196:21 part to adopt or adopt portions of it or however. 196:22 With 50 different states, you know, there's -- it 196:23 was made available to everyone to use it as they 196:24 saw fit.		introduced into this case through plaintiffs' expert, Lacey Keller.
201:04 - 202:16 201:04 Q. As you discussed earlier, one of the 201:05 Board of Medicine's functions is to license 201:06 doctors and other medical professionals, 201:07 correct? 201:08 A. That's correct. Allopathic 201:09 physicians. 201:10 Q. How often do doctors have to be 201:11 relicensed by the Board? 201:12 A. Every two years. 201:13 Q. And what is the purpose of licensing 201:14 doctors? 201:15 A. In order to ascertain that they are 201:16 still practicing with a proper degree of 201:17 knowledge and professionalism. 201:18 Q. So the Board's license is an 201:19 endorsement of the doctor's credentials? 201:20 A. Yes. 201:21 Q. And the Board's license is an 201:22 endorsement of the doctor's ability to 201:23 continue to make medical judgments? 201:24 A. Yes. 202:01 Q. And part of the reason that the Board 202:02 of Medicine licenses doctors is to protect the 202:03 public; is that right? 202:04 A. That's correct. 202:05 Q. So the public can have confidence that 202:06 a licensed doctor is legitimate? 202:07 A. Yes. 202:08 Q. And licenses ensure that only doctors 202:09 can prescribe controlled substances? 202:10 A. I think physicians, yes. 202:11 Q. And if the Board of Medicine knew that 202:12 a doctor was engaged in diversion of 202:13 controlled substances, they have the authority 202:14 to pull the doctor's license through the 202:15 disciplinary procedures we talked about? 202:16 A. Through the disciplinary process, yes.	**Re: [201:04 to 202:16]** Vague (including time-period) Relevance; Speculation (202:5-7)	**Re: [201:04 to 202:16]** The questioning is not vague and does not call for speculation. Mr. Knittle was the executive director for the WV Board of Medicine, one of the primary regulators of prescribers in West Virginia, for 12 years. The question is relevant to the board's operations and why and how the board licenses prescribers.
202:17 - 202:24 202:17 Q. And the Board of Medicine also has the 202:18 authority to decide not to relicense a doctor? 202:19 A. It would have to have a basis for 202:20 doing so. 202:21 Q. If the Board of Medicine knew that a 202:22 doctor was engaged in diversion of controlled 202:23 substances, would they have the authority to 202:24 decide not to re-license a doctor?		
203:01 - 203:04 203:01 A. It would have to be proven through the 203:02 complaint process for that to occur. We 203:03 couldn't just randomly say, "Well, we don't 203:04 think we're gonna give you your license back."		

Designations		Objections	Reponses
203:05 - 204:01			
203:05	Q. So if a doctor/licensee went through	**Re: [203:05 to 204:01]**	**Re: [203:05 to 204:01]**
203:06	the disciplinary process and was found to have	Relevance;	The questioning is
203:07	engaged in diversion of controlled substances,	Speculation; Vague (including	not vague and does not call
203:08	the Board of Medicine would have the authority	time-period)	for speculation. Mr. Knittle
203:09	to decide not to relicense a doctor at that		was the executive director for
203:10	point.		the WV Board of Medicine, one
203:11	A. It would be a revocation of his		of the primary regulators of
203:12	license with the -- with the possibility that		prescribers in West Virginia,
203:13	he would not be able to renew again.		for 12 years. The question is
203:14	Q. What is the -- what information does		relevant to the board's
203:15	the Board of Medicine look at when it decides		operations and why and how the
203:16	whether or not to license a doctor?		board licenses prescribers.
203:17	A. We would look at -- there's a series		
203:18	of questions that the physician must answer -		
203:19	I think there's 12 or 15 of them - that has to		
203:20	do with their mental fitness, their physical		
203:21	fitness, any issues with possible addictions		
203:22	themselves, any court issues or legal issues		
203:23	that may affect their practice.		
203:24	And there's a -- there's a list		
204:01	of those on the page for the renewal section.		